The CHIRONIAN.

July, 1909

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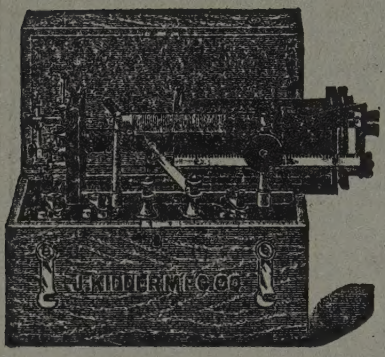

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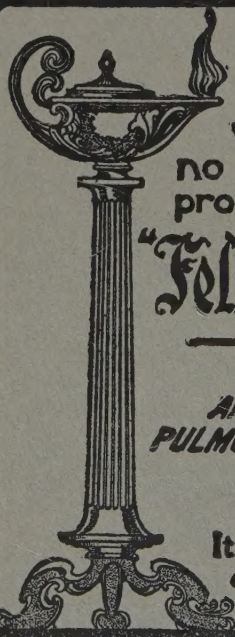

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THE CHIRONIAN.

VOL. XXVI JULY, 1909 No. 1

THE ROLE OF THE PROSTATE IN CHRONIC GONORRHŒA.

By Dr. E. Everett Rowell, Stamford, Conn.

It is the purpose of this paper to briefly consider the intimate relationship existing between chronic gonorrhœa and chronic gonorrhœal infection of the prostate.

Some of our text books would lead us to believe that gonorrhœa and prostatic infection bore no relation to each other and all one needed to cure a case of chronic or recurrent gonorrhœa was a few sounds, a two drachm syringe and some astringent or one of the popular silver preparations. At the same time extensive research work by some observers has taught us that gonorrhœa of the prostate is one of the most serious conditions with which we, as physicians, have to deal.

It is the most frequent complication of gonorrhœal urethritis, the hardest to cure, and its tendency towards chronicity one of its main features.

In spite of these facts, however, few of us appreciate the extensive amount of damage and the irreparable harm it does both to the patient and to those with whom he comes into intimate contact.

Noeggerath made extensive observations and found that 80 per cent. of married men have had gonorrhœa and that ninety per cent. of these had never been thoroughly healed.

Brothers examined seventy-two husbands of childless wives and found that the husband was sterile in 50 cases. In every instance the trouble was in an old double epididymitis or an uncured gonorrhœa of the prostate.

Prostatic hypertrophy is accepted by some as the results of an uncured gonorrhœal prostatitis.

Between six and seven thousand people in the United States are blind as a result of Ophthalmia Neonatorum.

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Pozzi finds that in laparotomies performed on women for pelvic inflammation, 75 per cent. are attributable to gonorrhœa.

While an uncured gonorrhœa in the male is not responsible for all of this, it is responsible for a large proportion of it.

In looking at the anatomy of the prostate and adnexia we can easily see why prostatic involvement occurs so frequently in gonorrhœa, and why, once infection takes place, it is so difficult to cure.

The prostatic urethra is 1¼ inches long and presents anteriorly on its floor the veru montanum in front of which the two openings of the ejaculatory duct are placed. Each side of the veru montanum are the prostatic sinuses into which open some 15 or 20 prostatic ducts. A gonorrhœa commencing at the meatus and extending backwards to the prostatic urethra could not very well avoid infecting the "thousand mouthed, succulent prostate," as Keys terms it.

Casper states that in 85 per cent. of all cases of posterior uretritis prostatic involvement could be demonsrated.

Once this portion of the urinary tract is infected it provides with its ducts, glands and sinuses, a hiding place for the gonococci from which they can only be removed, if at all, with the greatest of difficulty.

There is a great deal of truth in the statement made by Wolbast, "were it not for the prostate, gonorrhœa would be a curable disease."

While every case of gonorrhœa does not of necessity infect the prostate, the great proportion of them do so. Chetwood and other men claim that in every case of gonorrhœa there is an extension to the posterior urethra even though there are no subjective symptoms to show for it. If this statement be true, and admitting that it is with difficulty we can cure an infection of the prostatic urethra, we can readily see that the prostate is responsible for a great many cases of chronic gonorrhœa. In fact it is claimed by some writers that chronic gonorrhœa and chronic gonorrhœal prostatitis are synonymous terms. Truly the role of the prostate in chronic gonorrhœa is an important one.

I have never seen a case of chronic gonorrhœa if stricture were absent in which more or less involvement of the prostate and adnexia did not exist.

It is important that we realize that a large number of cases of

prostatitis are without any subjective symptoms whatever. The prostate may apparently feel normal to the touch, yet an examination of the massaged secretion will show the presence of pus.

In other cases a persistent turbid urine with or without a slight discharge are the only symptoms complained of. This turbidity will disappear under irrigation of the bladder only to reappear from the diseased prostate when the irrigations are stopped. In other cases we have that old familiar history, a persistent discharge with or without frequency of urination and possibly with painful ejaculations. The discharge disappearing from time to time only to reappear after alcoholic or venereal excesses, but like the poor "always with us."

The patient presents himself for examination with a full bladder, if any discharge is present a specimen is taken for examination. He then expels most of his urine, washing out the entire urethral tract, his prostate and vesicles are vigorously massaged, and he then passes his remaining urine, washing out the expressed secretions which are examined for pus and gonococci.

The following cases will illustrate chronic gonorrhœa due to prostatic infection:

T. I. American, aged 31, *December,* 1909. Had an attck of gonorrhœa about 5 years ago. At that time he had quite a little bladder irritation. He was treated for about six months and then, as his discharge had ceased was discharged as cured. He apparently remained well until last July, when a discharge appeared accompanied by frequent urgent and painful urination.

He claims not to have had sexual connection for a period of three months prior to the appearance of the discharge. At present he has some discharge and frequent urination.

Both glasses of urine are cloudy. No stricture is appreciable.

The prostate is enlarged, hard and extremely tender. The vesicles are enlarged. Upon massage a quantity of prostatic fluid was obtained which contained blood, pus and some gonococci.

He was treated every other day by prostatic massage, followed by irrigation of Nitrate of Silver 1-10,000. After a few treatments he started to improve, and has improved steadily since. His discharge has ceased and the urine he passes is clear. The urine obtained after a massage, however, is still loaded with pus cells, and, consequently, he still receives treatments twice weekly.

J. D., American, age 36. Came for treatment on November 8, 1908.

He contracted gonorrhœa about three years ago and has never been entirely free from the discharge since. At times it would be only a drop in the morning, with a few shreds in the urine, at others he would have a profuse discharge. During this time he was constantly treated by physicians by irrigation and the passage of sounds.

His prostate has never been examined. An examination of urine shows a few shreds in first glass of urine, second glass clear, third glass after massage full of prostatic secretion containing much pus and a few gonococci. The prostate is enlarged, hard and tender. No stricture present, as a No. 35 sound (French scale) passing easily into the bladder.

Diag.—Chronic Prostatitis.

He was treated by prostatic massage followed by irrigation of Nitrate of Silver—1-10,000. Once weekly he received a deep injection of Nitrate of Silver, 2 per cent. Under this treatment for three months the patient has apparently cleared up, the discharges having ceased, and the pus and gonococci disappearing from the massaged urine. As a precautionary measure I am still treating the patient once weekly and closely examining the prostatic secretions for gonoccocci or pus cells.

His case illustrates typically that chronic gonorrhœa is synonymous with chronic prostatitis. The gonorrhœa persisting until treatment was directed to the prostate itself.

J. R., American, age 22. *April,* 1908. Gonorrhœa two years ago. After a few months discharge ceased and the patient was considered cured. From time to time noticed a slight discharge which would disappear in a few days under a simple astringent injection. This discharge would usually appear after excessive drinking or sexual connections.

He now has a moderate amount of discharge and some frequency of urination. The first glass of urine is quite shreddy and the second only very slightly so. A No. 34 sound passes easild into the bladder. The prostate is slightly enlarged and tender. The vesicles were apparently normal. The diagnosis was chronic prostatitis. Gonococci could not be demonstrated in the expressed secretion. The patient received prostatic massage followed by intra-vesicle ir-

rigation of 1-10,000 solution of Nitrate of Silver. He received this treatment every other day for six weeks, and then once weekly for two months. As the discharge and frequency of urination had ceased, the urine clear and an examination of the expressed contents of the prostate negative, the patient was considered cured. In February I again examined the patient with negative results.

While I was unable to discover the gonococci at any time in the case I am convinced that they were present and the cause of his prostatitis.

CONCLUSIONS TO BE DRAWN.

1. That the vast majority of cases of chronic or relapsing gonorrhœa are those in which the gonococci have infected the prostate.

2. That the urine passed by the patient may be clear, but the urine passed after massage of the prostate may be loaded with pus and contain gonococci.

3. That in every case of chronic gonorrhœa a thorough examination of the prostate and adnexia should be made.

4. That in no case should a man be allowed to marry who has suffered from gonorrhœa until the secretion obtained from prostatic massage is free from gonococci.

5. That while the prostate may feel normal to the touch an examination of the massaged discharge may reveal the presence of gonococci and pus cells.

PATHOLOGY OF MENINGITIS.*

E. Welles Kellogg, M. D.

Member of the Helmuth Club.

To the general practitioner, the exact pathological condition of meningitis, in whatever form it presents itself, either means nothing or he realizes that there is some inflammatory condition of the brain and spinal cord, but to the necroscopist, it means everything of interest and value, so, perhaps, strictly speaking, the real true interest is only for him, when he has the chance to examine the pathological lesions presented by this disease.

Upon examination, dependent upon the duration of the disease,

*Read before the State Society, Albany, February 10, 1909.

he will find every degree of inflammation, from a simple congestion to a purulent exudation, of the meninges of the brain and cord, particularly the pia mater and archnoid; besides, the ventricles of the brain may be filled with serum or pus and, perhaps, congestion, either of the lungs, liver, kidneys, spleen and stomach, and if the case be one of tubercular origin, the characteristic tubercular lesions of the lungs, joints or peritoneum, and especially the miliary tubercles upon the choroid plexus, would be present.

The most interesting and important feature is to make the correct diagnosis; *i. e.*, to give the exact cause for the inflammatory process and I am afraid that in the majority of cases, the exact cause is not looked for; the symptoms are generally recognized and the case treated, regardless of the cause. I must confess that it is better to begin such treatment, as it is not always possible to determine the exact cause and the patient would die, without any attempt to relieve the symptoms; in fact, death often comes so quickly that a bacteriological examination helps but little.

The micro-organisms that give us an inflammatory condition of the meninges are mainly, The Diplococcus Intra-cellularis of Weichselbaum or The Meningococcus, The Pneumococcus, The Tubercle Bacillus, The Streptococcus and the Gonococcus, consequently the serum or exudate from these lesions should show the micro-organism and in order to show which one, it is necessary to get a sample of the cerebro-spinal fluid by lumbar puncture.

To obtain this fluid, the patient should lie on the right side with the knees drawn up and the left shoulder depressed. Everything, the hands of the operator, the skin of the patient, the syringe and needle and the test-tube, should be absolutely sterile. Make the puncture between the third and fourth lumbar vertebrae, on a level with the spinous processes, about one-third inch or 1 c.m. to the right of the median line, and insert the needle upward and inward towards the median line. At a depth from two-thirds to one inch and a half or 2 to 4 c.m., the needle should enter the subarachnoid space and the fluid flows out drop by drop. Collect from 10 to 15 c.c. of this fluid, free from blood, if possible, and after withdrawing the needle, seal up the wound with a sterile dressing. This procedure is not dangerous, and from a surgical standpoint often proves of great value, as the withdrawal of this fluid, will cause a relief

of the symptoms, due to the decreased pressure of the fluid within the membranes. Whether it is necessary to anæsthetize the patient for the procedure, depends upon the existing conditions, and the wish of the operator.

If an immediate diagnosis is not asked for, it is better to have a culture growth or an animal inoculation but as this will take from 24 hours to several days, dependent upon the cause of the infection, it may not be advisable to wait for it as the case may die in the meantime, so I shall deal only with the immediate examination of the fluid, and here, as the micro-organism may be so disseminated, it is impossible even after several examinations to give a definite answer.

If the fluid is turbid and has a sediment, it is not necessary to centrifuge, as is the case when the fluid is clear. Take the sediment and spread it upon the cover-glass, dry, fix and then stain by Gram's Method, the advantages of which, are that certain bacteria will take a certain color while other bacteria will not; *i. e.*, certain bacteria will retain the Gentian-violet stain, while others will be decolorized by the Iodine solution, and take the stain of Bismarck Brown. Consequetly, we must remember that under this method, the Pneumococcus, Tubercle Bacillus and Streptococcus are positive, *i. e.*, hold the violet color, while the Gonococcus and Meningococcus are negative, *i. e.*, take the brown color, so upon examination, if we know the characteristic formation of either micro-organisms, we can definitely state, whether it is due to either one of the first three or to one of the latter.

To differentiate between the first three, take another smear upon a cover-glass, fix and stain it by the Ziehl-Neilsen or Gabbet or Pappenheim Methods, by which, the Pneumococcus and Streptococcus are stained blue by the Methylene blue, while the Tubercle Bacillus will retain the red stain of the Carbol-fuchsin. The absence or presence of the Pneumococcus or Streptococcus, gives you a positive diagnosis between these two, but it is common to find these two micro-organisms associated together in this disease.

To differentiate between the last two, Gonococcus and Meningococcus is a difficult task as the organisms are similar in appearance, occur as diplococci, are generally found within the pus cells and take the same stains, but if we remember that these two organisms

are not liable to occur in the same tissues, that it is rare to have meningeal symptoms from the gonococcus, that the inoculation of the fluid into the guinea-pig or other lower animals, if gonorrheal, would not give rise to meningeal symptoms, that the gonococcus does not usually grow upon the ordinary culture media and that we have a previous history of the case as a guide, we should not confuse these two.

In the diagnosis between Meningitis and Tubercular Meninigitis, although in the latter we have a history of childhood with a tubercular history of symptoms, if the latest discovery of the tubercle bacillus in the blood is confirmed, and I think that it will be, as it has already been confirmed by the pathologists of the Flower and Metropolitan Hospitals, several times within the last week it is certainly a decided advance in the early diagnosis of tubercular conditions.

It is certainly a very simple and most interesting experiment, and is carried out as follows: Add 5 c.c. of the patient's blood to 10 c.c. of a normal salt solution containing enough of a 2 per cent. sodium citrate solution, to give a neutral reaction. Shake thoroughly and let the solution stand over night, spread the precipitate upon a cover-glass, dry, wash off the haemoglobin with distilled water and then stain according to the Ziehl-Neilson Method, and the tubercle bacillus, if present, will be found colored red.

In case you are unable to find the micro-organism, and all other signs are not positive, take a drop of the patient's blood, make a smear of it upon the cover-glass and stain by Wright's method. If you find a marked increase of the lymphocytes, you are justified in regarding the case as tubercular, as in the other forms the polynuclear neutrophiles are generally increased.

111 East 59th St.

APOCYNUM CANNABIUM, AN ANTIDOTE FOR ALCOHOL POISONING.

D. E. S. Coleman, Ph. B., M. D.

"Twenty drops of Apocynum cannabinum decoction in a tumbler of water will put an 'old soak' on his feet quicker than any other remedy." ("Elements of Homœopathy," Boericke and Anshutz.)

This was my introduction to the use of this remedy in alcoholism, and my results with it have been gratifying to the extreme. Lately I have given larger doses than recommended above.

When I first see a patient suffering from acute alcoholic poisoning, I give him a teaspoonful of the decoction in a glass of water. Then I put three teaspoonfuls in a glass of water, and order two teaspoonfuls of this mixture to be given every half hour until I make my next visit. I repeat the teaspoonful dose in from six to twelve hours if necessary. I diminish the quantity of alcohol at the beginning of the treatment, mixing liquid peptonoids and water with the whiskey. In this way I am able to satisfy the craving and diminish the quantity of alcohol more rapidly than when whiskey alone is given. The liquid peptonoids act as a food also. Of course, the patient must never know of this substitution, and I have fooled some of the wisest and most experienced topers in New York.

Briefly, the results are these: Patients who formerly took from three weeks to as many months on each spree, now are brought around in a few days. Apocynum also seems to stop the physical craving. If any craving does exist after the patient has sobered up I give teaspoonful doses of the decoction in a glass of water from two to four times a day until no desire remains. About a dozen cases so treated is my clinical record.

What is the modus operandi of Apocynum in this condition? *Simply antidotal.* It is a chemical antidote to alcohol as well as a physiological. This is proven by the fact that the decoction is much more efficient than the tincture, and dilutions run in alcohol are of no value.

I believe that the action of an antidote to the primary effects of a poison is in perfect accord with the homœopathic law. (See "Physiological Antidotes and the Homœopathic Law," read before the International Hahnemannian Society, June, 1907. *Homœopathic Recorder,* November, 1907.)

EDITORIALS.

With volume twenty-six, THE CHIRONIAN appears under new management. Dr. Louis René Kaufman has found it impossible, owing to the demands of a growing practice, to longer continue the editorial and business work of the paper.

All readers of THE CHIRONIAN who have its interests at heart will note this change with regrets, as Dr. Kaufman has been a hard worker in the interests of the paper and has done more than any one to bring it up to the present standard of excellence.

However, it is comforting to know that the doctor has accepted a place on the advisory staff, where his personality will be felt and where his judgment and knowledge of the affairs of THE CHIRONIAN will be of great help to the present management.

THE CHIRONIAN is pleased to note a rapidly diminishing number of letters written to editors of the medical and lay press on the subject of anti-vivisection by persons who, through mistaken zeal or gross ignorance of the subject, are guilty of the most misleading and fictitious statements. Several bills have been before the Legislature purporting to regulate this matter, but happily, they died before the Assembly adjourned.

In speaking before the Assembly Judiciary Committee on these bills, Dr. Jacob Gould Schurman, of Cornell University, said in part:

"Who is the genuine humanitarian? Is it the man who wants for himself every variety of animal food, but who is so indifferent to the sufferings of his fellow men that he will not allow scientist to conduct their experiments on animals for the relief of those sufferings? The question answers itself. The real humanitarian is the earnest, patient and humane investigator who, with the minimum amount of pain to animals compatible with his high endeavor to relieve the sufferings of mankind, devotes himself to enlarging our knowledge of the nature and cause of human disease and discovering the means of their prevention and cure. The man who opposes this beneficent work is either a misguided sentimentalist or an unthinking enemy of his own species."

Dr. Moses Clegg, bacteriologist of the Bureau of Sciences at Manila, according to dispatches of recent date, has succeeded in cultivating the leprosy bacillus. He has made five separate cultures of the bacillus and carried all of them through five successive generations. Dr. Clegg used the organisms from both the bodies of victims of leprosy and the living lepers. He has been equally successful in his cultures with germs of amebic dysentery, establishing symbolic relationship between the germs of the two diseases.

The Bureau of Science has prepared a leprosy vaccine, and expects to carry forward a series of experiments for the purpose of establishing a specific treatment for leprosy. Dr. Clegg is the son of a prominent Arkansas physician. (From the Buffalo Medical Journal.)

It is to be hoped that the time is not so far distant when the homœopathic school in general and a few individual members in particular will reach a point where their dignity will forbid the uncalled for attacks on our friends, the enemy.

One can scarcely pick up a magazine of our school and not find more or less of its space devoted to long arguments setting forth the merits of Homœopathy as against the utter uselessness of the others. Of course we believe in the law of similars, or else we would not be practicing it; we believe our colleges are teaching a better system of therapeutics than others or else we would not have graduated from them or be supporting them, but wherein is the value of harping on that theme so continually? Does it strengthen our faith so much to be told that there is no good in any others? Does it add to the harmony and good feeling that should prevail throughout the great body of the medical profession to always be sneering at those of a different faith? Does anyone imagine that a member of the old school will forsake his teachings because some journal prints half a dozen pages to prove that Dr. Osler is not a strong believer in the power of drugs?

Our school has made a strong and steady advance in the art and science of medicine, but the end is not yet, so why not devote more time to seeking after the truth that lies before us and less in useless criticism of others.

"Thou hypocrite, first cast out the beam out of thine own eye, and then shalt thou see clearly to cast out the mote out of thine brother's eye."

THE CLASS REUNION.

One of the best ways to foster college spirit is by means of class reunions. These have been in vogue at the New York Homœopathic Medical College and Flower Hospital for several years. The reunions held this year were, without doubt, the most successful so far held. A systematic effort was made by the Board of Directors of the Alumni Association, to get each class having a five year anniversary to have a special reunion. As the result of this, the Classes of 1874, 1879, 1884, 1889, 1894, 1899, and 1904, all had special meetings. Old days were recalled, old stories retold, and old friendships renewed. There was an impetus given to a renewed interest in the affairs of our Alma Mater which will bear good fruit in the future. One feature of each reunion was the appearance of our ubiquitous dean, Dr. Copeland, at every one of them.

THE MEDICAL ERA'S GASTRO-INTESTINAL EDITIONS.

During July and August, The Medical Era, of St. Louis, Mo., will issue its annual series of issues devoted to gastro-intestinal diseases. The July number will take up the usual bowel disorders of hot weather and the August will be devoted entirely to Typhoid Fever. These issues always attract considerable attention.

The editor will forward copies to physicians applying for same.

TWENTIETH ANNIVERSARY OF THE CLASS OF 1889.

The Class of 1889 was twenty years old this Commencement. Of the thirty-seven who graduated, eighteen were present, a good representation.

There were Bunn, of Orange, N. J., now known to fame as a surgeon; Bowen, Connell, and Updyke, all of Jersey City, and all prosperous; Schaffmeister, ex-coroner, of Ossining; Jenkins, of Binghamton, where he is on the visiting staff of a hospital, where both schools meet on an equality; Morrison, of Newark, New Jersey; Wood, of Providence, Rhode Island; and the New York contingent, Hallett, Roberts, Honan, Dowe, Hull, Sherman, Tuttle,

Allen, Laidlaw and Mills; all of these sat down to supper at the Hotel Manhattan on Wednesday evening, May 12. Bunn was master of ceremonies and every man made a speech.

Two things of importance were done at this meeting. The first was the unanimous adoption of the dean, Dr. Royal S. Copeland, who graduated at the University of Michigan in 1889, as a member of the class.

The second was this: The ambulance district, now covered by the Flower Hospital, is the the most important in the city. All New York knows of the Flower Hospital, comparatively few know that the Flower Hospital is homœopathic. The Class of 1889 voted that the word Homœopathic should be placed on the ambulance, if possible.

JULY NOTES.

The California State Homœopathic Medical Society held its Annual Meeting at the Hotel Vendome in San Jose on May 12th, 13th and 14th. On the programme we note the Alumni of Alma Mater in goodly number. The Class of '87 shows up well. The President, Dr. Pliny R. Watts, of Sacramento, and the former Vive President and President elect, Dr. Francis B. Kellogg, of Los Angeles, were '87. Among other names we note Dr. H. M. Bishop, '67, of Los Angeles; Jas. W. Ward, '83, of San Francisco; California's strong candidate for President of the Institute, Dr. E. S. Loizeaux, '02, of Patton, California; Dr. C. B. Pinkham, '09.

ALUMNI NEWS NOTES.

Dr. Gregg Custis Birdsall, '04, of Washington, D. C., has been seriously ill with appendicitis, necessitating an immediate operation by Dr. Helmuth, '89. He is convalescent now.

Dr. Bukk G. Carleton, 76; Dr. Sprague Carleton, '06, 75 West 50th Street. Telephone, 117 Plaza. Dr. Bukk G. Carleton will be in the office during July and August, only on Wednesday mornings. Dr. Sprague Carleton will be in the office every morning except Sundays. Evening and Sunday office hours will be discontinued

from June 9th to October 1st. Surgery and medicine of genito-urinary diseases exclusively. Out of town telephone, 29 Scarsdale.

It is with pleasure that Dr. Custis, '78, announces the return of his son, Dr. J. B. Gregg Custis, Jr., '07, and that on June 1st he will become his associate, giving special attention to surgery, obstetrics and emergency calls. Until September 20th his hours will be the same as the regular hours of the office or by appointment. Dr. Birdsall will continue to act as pathologist, microscopist and general assistant.

Dr. A. B. Norton, '81, 16 West 45th Street. Summer, 1909. Dr. Norton wishes to announce that he will be out of town from June twentieth to July fifteenth, and from July twenty-second to September fifteenth. Dr. William McLean, who has been associated with Dr. Norton for the last five years, will be in his office daily during his absence. Telephone, Bryant 191. Hours, 8 A. M. to 1 P. M. Disease of the eye exclusively.

Robert Lowell Wood, M. D., '04, 129 Hancock Street, Brooklyn. Special attention to urine and sputum analysis and to anæsthesia. Dr. Wood desires to announce that he will be absent from the city from June 30th to July 19th. During his absence patients are referred to Dr. Herbert C. Allen, 304 Clermont Avenue; Hours, 8-10, 1-2, 6-7:30, (except Wednesday evening). Sundays, by appointment. Telephone, 847 Prospect. All personal communications mailed to Dr. Wood's office will be forwarded, and will receive prompt attention.

Dr. Harry B. Dorr, '09, announces that he has settled with Dr. J. H. Bryan, '90, 221 Asbury Avenue, Asbury Park, N. J. Office hours, 8 to 10 A. M., 3 to 4 P. M. Telephone, 5.

Dr. John B. Garrison, M. D., '82, 115 East 71st Street, New York. Dr. Garrison desires to announce that, from June 1st to September 10th, he will be at his summer home at Hopewell, N. J. His consultation hours at 115 East 71st Street, will be from 10 A. M. to 12:30 P. M.; afternoons by appointment. From June 21st to 26th, inclusive, he will be in Detroit, Mich., attending the annual meeting of the American Institute of Homœopathy, and during July and August he will not be in New York on Mondays or Saturdays, but during all absences will have a competent assistant to attend to urgent cases. Telephone connection day and night. Summer hours, 10 to 12:30, and by appointment. Telephone connection, both places.

Dr. Wm. H. Van den Burg, '87, 30 West 48th Street, New York, announces the following consultation hours for the summer of 1909. June—Hours, 9 to 12 A. M. as usual, excepting the 21st to 26th, when he will be out of town. July.—Hours, 9 to 11 A. M. on Tuesday, Wednesday, Thursday and Friday of each week. August.—No regular hours. Consultations only by previous appointment. September 1st to 15th.—Same arrangement as August. After 15th regular hours, 9 to 12 daily, except Sunday. Dr. P. C. Thomas and Dr. H. G. Sayre, 44 West 77th Street, (hours, 9 to 11 and 5:30 to 7; telephone, 6627 Riverside) will see patients in Dr. Van den Burg's absence.

Dr. G. G. Van Matu, 682 Greene Avenue, Brooklyn, announces that he will be at his cottage, "The Chequit," Keansburg, Monmouth, N. J., from June 15 to October 15, and at the Brooklyn office on Tuesdays, 10:30 to 2:30 only.

Dr. Samuel Barlow Moore, '01, 263 West 81st Street, will be out of town from June 15th to July 10th. Patients are referred, during his absence, to Dr. A. L. Root, 114 West 81st Street. Hours, 8:30 to 10:30 A. M., 6 to 7 P. M. Telephone, 1477 Riverside.

Dr. J. G. Maeder, '85, announces the opening of his new office July 1st, 1909, at 123 West 121st Street, New York City. Office hours, 9-10, 2-3, 7-8. Sundays, 2-3. Telephone, 703 Morningside.

Dr. A. Berghaus desires to announce that during his absence in Europe from May 26th to August 17th, Dr. J. S. Gains will attend to his patients at the Sherman Square Hotel, 200 West 71st Street. Office hours, 11 A. M. to 1 P. M., 5:30 to 7 P. M. Sundays, 4-5 P. M. Telephone, 3855 Columbus. Night calls, 4612 Columbus.

Stacy Watkyn Boyle, M. D., announces that he has opened an office at 8 Field Point Road, Greenwich, Connecticut. Hours, 8-10, 1-2, 6-7. Sunday, 9-10. Telephone, 192.

Soon after his return to Washington, after attending the re-union of the Class of 1904, Dr. Gregg Custis Birdsall was taken violently ill with appendicitis, and Dr. Helmuth, who was summoned from New York, operated upon him in haste. He is now making a slow recovery, and will go to Paterson, N. J., for the summer, as soon as his condition permits.

At the June meeting of the Kings County Society, Dr. Herbert L. Northrop, Dean of Hahnemann College, of Philadelphia, read an interesting paper on "The Peritoneum."

Dr. John L. Moffat, of Brooklyn, announces that during August his address will be 476 Maine St., Orange, N. J.

His practice will be in the care of Dr. Charles E. Paine, 653 St. Mark's Ave. Telephone, 2385 Bedford. Hours, 8 to 1 and 7 to 8. Sunday by appointment only.

On June second Dr. Roger William Moister, '02, of Summit, N. J., married Miss Bertha E. Corbin, of New Britain, Conn., at the First Baptist Church in that city. Dr. Roy Upham.'01, and Dr. Geo. Olcott, '09, acted as ushers and Dr. Joseph H. Fobes, '01, was groomsman. Dr. and Mrs. Moister will reside in Summit, N. J.

Dr. Louis Rene Kaufman, of 256 W. 57th St., announces that until September 1st his night telephone call will be Morningside 4590.

BORN.

On Sunday, May 30th, 1909, to Dr. and Mrs. B. G. Carleton, '76, of New York, a son.

On Sunday, May 2d, 1909, to Dr. and Mrs. L. R. Kaufman, '04, of New York, a daughter.

CORRESPONDENCE.

Dr. L. R. Kaufman,
256 West 57th St., City.

Dear Doctor:—

We have just read Dr. Ghose's letter in the May number of the CHIRONIAN in which he mentions our name in connection with the Indian remedy, Ficus Religiosa.

As the statements in his letter are untrue and tend to cast discredit on us as homœopathic pharmacists, we trust you will give us space to answer the same.

Dr. Ghose says in his letter, "I take this opportunity of saying that I never supplied the tincture to Messrs. Boericke & Tafel, etc." This statement is untrue. The doctor did supply us with the tincture. He has evidently forgotten.

We send herewith copies of three letters which he wrote to us at the time of his sending us the tinctures. The originals of these letters are here in our files at 145 Grand Street.

The balance of our stock of Ficus Religiosa is here in sealed bottles, seals unbroken, just as we received it from his agents.

We never made or sold a tincture of Ficus Religiosa from the dry plant.

Very truly yours,

BOERICKE & TAFEL.

December 17th, 1903.

Boericke & Tafel,
145 Grand Street, New York.

My Dear Sirs:—

Many thanks for your kind letter of Nov. 4th, 1903. I also got the letter of E. P. Anshutz. You shall positively get both the tinctures as soon as possible. All the homœopathic pharmacies of our country are only selling firms. They have no knowledge of pharmacy and chemistry. They bring the medicines from America and other countries and only sell them. Had they been placed under the personal supervision of qualified medical men, they would have been able to do more for Homœopathy than they do at present. Dr. W. Schwabe, of Germany, took a large supply of these remedies from me a few days ago and so, I could not comply with your kind request so long. "Nyctanthea" has been ready and "Ficus Religiosa" will be made ready after a week. After that time Hahnemann Home will send the tinctures to you.

* * * * * *

(Signed.) SARAT CH. GHOSE.

January 21, 1909.

Boericke & Tafel,
145 Grand Street, New York.

Gentlemen:—

I have seen the letter which you kindly wrote to Babu Satis Ch. Dutt, of Hahnemann Home. The medicines (Ficus Religiosa and Nyctanthea) will be sent to you by the next mail.

Both the tinctures are prepared according to the rules of *Class I of your American Pharmacopoeia.* The amount of the drug power of the tincture *is* ½. The dilutions should be made in the following manner:

According to the centesimal scale. 2 drops of the tincture and 98 drops of the dilute alcohol will make the 1st potency. 1 drop of the 1st potency and 99 drops of alcohol will make the second potency and so on.

According to the decimal scale. 2 drops of the tincture and 8 drops of dilute alcohol will make the 1x dilution; 1 drop of the 1x dilution and 9 of dilute alcohol will make the 3x dilution; all other dilutions are made with the alcohol.

* * * * * *

(Signed.) Sarat Ch. Ghose, M. D.

March 23d, 1904.

Messrs. Boericke & Tafel,
145 Grand Street, New York.

Dear Sirs:—

Your esteemed favor of the 19th ultimo was only received. I shall be very glad to send you the remaining portion of Ficus Religiosa at an early date. I shall prepare the tincture within a week and shall send it to you as soon as it is done.

* * * * * *

(Signed.) Sarat Ch. Ghose.

ANNOUNCEMENT.

The twenty-sixth session of the Southern Homœopathic Medical Association will be held in Hot Springs, November 15th, 16th and 17th, 1909. We earnestly urge every homœopathic physician in the Southern States to become a member of the Association and aid in the work of propagandism now being carried on all over this country with more vigor than ever before in the history of Homœopathy.

Organization and propagation are more imperative now than ever and it is a duty each one of us owe to the system of medicine we practice, to support our national, sectional, State and local organizations, if we are to maintain our rights before legislative bodies and

secure the representation to which we are justly entitled in the medical departments of State Universities and other medical institutions of this country that are supported by taxation of the public. This can be done if we will all join together and work with this purpose in view.

The benefit of good and successful meetings for the propagation of Homœopathy in the South are already apparent and aptly demonstrated by the results of the last meeting of the Southern in New Orleans, as quite a number of letters have been received from several different States making inquiry in regard to homœopathic treatment and in every instance they came from places where we have no homœopathic physician. From this it is but reasonable to suppose that where there were representatives of our school, others consulted with them. This also renders invalid that old excuse, "I can never attend the meetings, so can derive no benefit from the organization," which we so often hear as a reason for not becoming a member of the Southern Association.

The last meeting of the Southern was one of the best held in many years and there is no reason why the next session at Hot Springs should not be even more successful, if we will only work to make it so, but we must all work together with this purpose in view. Spasmodic efforts and an occasional good meeting will be of little avail in the work of propagation, they must be continuous, we must have good meetings every year to accomplish our purpose and obtain lasting benefits, else the good one may do is lost before we hold another.

Let us again urge every Southern homœopath to support the Southern by becoming a member, give it his moral as well as financial support and contribute his mite to the cause. You need the organization and the organizaztion needs you. "In union there is strength."

EDWARD HARPER,
President.
WM. A. BOIES,
Secretary.

DR. JOHN E. WILSON, President. DR. JAMES E. TYTLER, Secretary.

TRANSACTIONS OF THE ACADEMY OF PATHOLOGICAL SCIENCE.

Regular Meeting, April 23, 1909.

CASE OF OSTEO-MALACIA.

Preliminary Report, By Dr. J. H. Fobes.

The patient, a woman of 54, a widow, first came under observation September 2, 1908. The only points of interest in her past history are a family history of tuberculosis, and a history of bronchitis in her early youth. For nearly a year before coming under treatment, she had been under a severe nervous strain, taking care of her husband, who suffered from paraplegia, and was very much run down. While walking along the street she caught her heel in the curb-stone, and while falling felt a crack in her left hip before she struck the earth. She could not rise, but was taken to the hospital, where a diagnosis was made of intra-capsular fracture or fracture of the small part of the neck of the femur. The case proceeded very well until eight weeks later. She had left the bed and could walk around on crutches, when about the middle of November she sat down rather suddenly one day and felt something snap in the same leg, which she declared was broken. This time it was a compound fracture of the middle third of the femur, with a good deal of over-riding. Extension was applied, and an X-ray picture was taken to see the pathological condition of the bone. From this picture one can see the thinness of the bone near the periosteum, and the thickening of softer tissue between the periosteum and the marrow. Dr. Dieffenbach advised against any attempt to correct the over-riding in this case. He had seen a good deal of such work in Germany, where it is more or less common, and it was considered best not to attempt to correct the deformity. The patient was put on Armour's bone marrow and hydrolene, and the feeding pushed as much as possible. The remedy was Phosphorus and Calc. phos. A later picture showed the result of the treatment. The upper fragment of the bone had lost much of the thin appearance and was more like normal bone, but the lower part retained the same condition.

Dr. Fobes also showed another picture taken three or four weeks ago, to find out how far the process had gone. The left side of the body was taken, and the two tibias compared. The thinness of the bone on the injured side can be seen, showing that there was destruction of bone, whereas the other side showed good bone formation. The next point was to determine whether the arms were affected, and a picture was taken of one arm, showing it to be fairly normal.

At present it was not considered wise to allow her to use the limb without protection, so a side bar brace was constructed and applied, which enables her to walk about with crutches fairly well.

The history of this condition shows that the pathological process consists of a mild nflammation of the marrow, causing it to become like embryonic marrow, the bone becomes dissolved and softened, the marrow enlarges and grows toward the periphery of the bone, and the bone under the periosteum becomes thinner. and according to the rapidity of the process fractures or bends result. The condition is usually due to the puerperal state, and some interesting experiments have been performed along this line. A case having shown this condition during the puerperal state, was operated upon and both ovaries removed, and later X-ray pictures showed great changes that had occurred in the constituents of the bone, and from this it was concluded that the ovaries have some influence upon the condition. This patient, however, is past her climacteric. and Warren states that such cases would not respond to this method of treatment.

The prognosis is usually unfavorable. The only other case which Dr. Fobes has been able to find from personal observation was one of Dr Leal's, in which the elder Dr. Helmuth was called in. This patient was a woman of 24, who had suffered from this condition during a puerperium, but developed fractures and finally after two years died from exhaustion, one bone after another being fractured.

In the present instance the process seems to be arrested, but, of course. it is too early yet to say positively, and a cure cannot be reported until the X-ray picture shows a much better condition of the bone, and the woman can walk about with comfort and safety, at least a year from the time the condition was originally noted.

DR. SLEGHT said there used to be an idea that lactic acid was the cause of the disease in the bones. He could not say whether this was the opinion held by pathologists today, but the acid has been found in the bones where it ought not to be, and a great increase of it in other secretions and excretions. This case is rather peculiar. as occurring in a woman past the child-bearing age, to which the disease is almost entirely confined. It usually occurs during or just after the puerperium. Very rarely it is found in the male. It is also unusual on account of the location, for the disease almost invariably begins in the pelvis or the bones of the spinal column, or in the ribs; and when once established it proceeds much faster than it seems to have done in this instance.

DR. HASBROUCK inquired whether Dr. Fobes had given the woman any of the usual homœopathic remedies. Sometimes we will find a remedy that suits a case in some other parts of the body—some particular remedy. Homœopaths can get marked effects from bone remedies properly attenuated. He recalled a case of a fractured leg which had been attended by one of the men then present, and well attended. That patient had had "the old Harry of a time," and the bone hurt him for six or eight weeks. Dr Hasbrouck

wrote to the surgeon who was treating him, a good homœopath, who said that he was giving the patient Calcarea phos. on general principles. Dr. Hasbrouck advised symphytum, and the man had no pain in 24 hours, and returned to his work in a very short time. This might not be the thing for every patient, but when you have pain in the long bones or in a break, try symphytum.

DR. COUCH inquired whether Dr. Fobes had made any urinary analysis, and, if so, whether Calcareous Salts were present, and if so, what variety?

DR. WILSON told of a meeting at Dr. Jacobi's which an acquaintance had attended and where some interesting papers had been read. An old German professor was there, and the elder Heitzmann, and the latter said that he had proved that lactic acid was the cause of osteomalacia, for he had fed it to some guinea pigs and they had developed the condition. The old German professor, who came from Heidelberg, asked Dr. Heitzmann if he had had any conrrol. He replied, yes, and they showed nothing under the same conditions. "Was the lactic acid pure?" "Yes." "How did you know it was pure?" "It smelt sour." "Then it was not pure, for lactic acid does not smell sour." He then said that this theory had, in regard to lactic acid, been advanced by many for years, but that it had been proved there was nothing in it.

DR. FOBES, in closing the discussion, said that the lactic acid theory has been held to be correct by many. Examination of the urine had showed phosphates. Replying to Dr. Hasbrouck. he said that when he first noted the conditions of osteomalacia he had consulted Helmuth's book and found the remedies, Lactic acid, Ruta, and Symphytum. but that this patient had not complained of pain, so he used Phosphorus and Calc. phos., except when he was prescribing for other symptoms. The bone marrow given was nothing more or less than ordinary bone marrow.

DR. COUCH then asked if there were any carbonates of lime present, or any effervescence, o both of which Dr. Fobes replied in the negative. There was no sign of the carbonates, but the triple phosphates were increased.

DR. WILSON remarked that it might be well to carry the form of the presentation of this topic in mind. It had been presented and discussed in an orderly and exhaustive manner, *i. e.,* clinically, pathologically, and therapeutically, and was the type which should be followed in the future.

CASE OF FLOATING CATARACT.

Presented By Dr. Hallett.

This is rather an unusual case, in which, as I shall ask you to observe, the cataract is present in either the anterior or posterior chamber of the eye, according to the position taken by the patient. In the morning it is usually back of the pupil, later in the day or if he bends forward his head, it is in front, and he can put it into the vitreous by throwing his head back or lying down. His objection to having the cataract in the anterior chamber is that

it becomes conspicuous, but he has no objection to its being in the vitreous. The conditon is due to a specific irido-cyclitis ten years ago, followed by atrophy of the ciliary body. and a weakening of the zonule. Under such circumstances the eye is soft to palpation and such straining as would accompany vomiting could dislodge the cataract, it would then float as freely as the fluid character of the vitreous would permit. If such a cataract were somewhat large and dislodged into the anterior chamber and fixed, it might by its size press upon the filtration angle and prevent a proper escape of the fluids from the eye and thus produce a secondary glaucoma; but as it is in this case it seems to disturb the patient very little, and being rather small it passes freely through the pupil, so it seems wisest not to attempt to do anything except by the use of eserine to keep the pupil so contracted that it prevents the cataract from appearing in the anterior chamber. The eye for a long time has been without vision.

DR. COUCH said that if agreeable he would like to make a few original remarks on the etiology of cataract. He has produced cataracts artificially outside of the body with animal lenses, by placing them in carbonic acid; and that Dr. Bissell, of Rochester, had also rendered animal lenses opaque by placing them in common salt solutions. Dr. Bissell's theory, as he understands it, is that salt solutions acted by dehydrating the lens substance. When, however, such lens is put in plain water again it assumes its original transparent condition. Not so, however, with carbonic acid cataract. Carbonic acid coagulates and turns white *all* albuminous substances, and when egg or serum albumen is placed in carbonated water they coagulate almost immediately. Dr. Couch's theory is that the carbonic acid is abnormally generated within the eye, and is the chemical cause of lenticular cataract as well as of glaucoma.

We should remember that oxidation of hydro-carbons goes on continuously in arterial as well as in stagnated circulations. If the gases of combustion are not removed local toxemia is sure to result. Carbonic acid paralyzes the muscularity of blood-vessels, and continued oxidation, of course, continues the vaso-motor paresis and the inflammation as well. In paralyzing the muscularity of blood vessels we get dilation and vascular distention, serum transudation. stagnation of circulation as well as increased intra-ocular pressure.

If those who are interested in eye diseases will rationally study the production of glaucoma, the incipient cases to glaucoma fulminans, they will find in carbonic acid a perfect cause for all of its phenomena.

By using up the oxygen we get a dark circulating medium, and by paralyzing the ciliary muscle we get rapid recession of the near point of vision, —a characteristic symptom. The great von Graeffe recognized vascular turgescence and serum transudation as the principal causative factor of increased intra-ocular pressure and glaucoma, and ascribed these phenomena to mechanical obstruction by venous constriction or abnormal by intra-venous projection into the lumina of vessels mechanically preventing the exit of blood from the eyeball as fast as received. His brilliant conception of the

operation of ridectomy for staying the progress of glaucoma and bringing about a cure has won for him enduring fame.

Dr. Couch feels that it is due to the partial paralysis of the intra-ocular blood vessels, and that all the symptoms of glaucoma directly result therefrom. It is a most serious problem to get rid of this paralytic poison when it is once produced in tissues. If for any cause you get a toxæmia of the blood within the eyeball, the blood vessels dilate, become distended and tortuous, and you naturally have exudation from the blood vessels, and in the presence of that toxic condition it is utterly impossible for the bloodd vessels, in this environment, to regain their normal contractile function and thus renew the circulaton and carry away the products of oxidation.

This clinical effect of carbonic acid on animal lenses could be tested by any one, by getting the eye of anyone of the lower animals and immersing its lens in carbonated water. Within twelve hours there would be procured a hard, perfectly white lens or cataract. It is a very interesting experiment. The white of a fresh egg placed in carbonated water will speedily result in the same dense white coagulation impervious to light. He hoped to present before the Academy at the next meeting some cataracts thus artificially produced.

In reply to a query as to how to account for the presence of carbonic acid in the eye, Dr. Couch said that it was always present in all kinds of blood circulations so that the poison is continually formed in glaucomatous conditions without the power or ability of the blood vessels to counteract and thus elminate the toxic blood and replace it with a healthier circulation.

Query. You regard it as due to the carbonic acid contained in the blood;

Ans. Yes, beyond the shadow of a doubt. Its action is chemical as well as paralytic. Dr. Cook, of 120 East 34th St.. New York, is now curing cataracts right along by the use of intermittent X-ray flashes, and his experiments tend to prove the value of my theory. The machine is made to give a flash of light intermittently. About three hundred flashes per treatment, once or twice a week, is used by him, the tube being eight or ten inches from the eye. By examination of the affected eye with the ophthalmoscope before and after treating a case of cataract he finds that the blood vessels though dilated, distended, and tortuous at first, after the X-ray has been used for about 300 or 400 flashes the blood vessels became normal in size and appearance. The vessels became contracted as a result of the stimulation and a cure resulted; the white opaque fibres being absorbed and the lens translucent with the return of normal circulatory conditions.

Dr. Cook was the first to use this method. and he is entitled to all the credit for his brilliant conception. He also cured cancerous conditions by the same method, and the reason is plain. It restores the normal contractility of blood vessels, normal circulation, and absorption of inflammatory products.

Dr. Couch recalled the case of a patient who was standing exposed for an hour on the street corner one cold, windy day and was seized that night with glaucoma. Operative interference was refused and she became blind. She has cataracts in both eyes, and only a faint perception of light remains.

Dr. Wilson asked why, if this was blood and general condition, both eyes were not more frequently attacked than is the case.

Dr. Couch replied that some people are right-handed and some left-handed, and local toxic conditions determined which eye becomes affected. There was no more definite reasons than that as to an exciting cause for unilateral cataract or glaucoma. In the case of the patient referred to it was doubtless due to the suppression of the skin function of exhaustion of toxic gases by a draught of chilling wintry winds, which resulted in the retention of these gases; the glaucoma following the tissue toxæmia. Both glaucoma or senile cataract may attack one eye or both eyes simultaneously.

Dr. Couch said that he was satisfied from his study of the action of the muscularity of blood vessels by CO^2 or carbonic acid produced by stagnation or the intra-ocular circulation, as explained above, is the real cause of lenticular cataract and that the same conditions continuing finally produces glaucoma with all of its attendant symptoms, increased intra-ocular pressure, and the formation of cataract, and pus, which is a chemical product, and not a product of the pus coccus as advocated by Cohenheim and accepted by the medical profession since 1868.

DR. SHEPARD said that 12 years ago he saw in the clinic a case similar to that presented by Dr. Hallett. The patient had been on a spree, and came into the clinic with a clear, transparent lens in the anterior chamber, nearly filling it; the capsular and zonule were intact. The patient was advised to come into the hospital, but he was unwilling. He said that he had fallen down an area way, and when he came to himself his sight was affected. He returned in a day or two, and the lens was again back in place.

As to the amount of violence which was required to dislocate it into the interior chamber and then replace it, he was unable to state, as the man had evidently been on a second spree. Extreme laxity of the zonule usually indicates a degeneratve process, and there is usually a cataractous lens, whether due to carbonic acid or to something else, he could not say.

DR. HALLETT said that it certainly seemed strange that a healthy lens could be displaced into the anterior chamber by even so much violence as Dr. Shepard's patient has sustained, and later return to its proper position without serious damage. The conditions in his own case would probably remain just as they are, the use of eserine being sufficient to contract the pupil and permit the lens to stay in the vitreous chamber. This gives the patient a black pupil, which is satisfactory to him. The lens could probably be extracted by modification of the usual cataract operation, but the eye is disorganized and degenerate, and some inflammatory process would probably follow such an effort, resulting in a shrunken eyeball. The present state is the more satisfactory.

In regard to the joint etiology of cataract and glaucoma, as referred to by Dr. Couch, he was not familiar with any such theory and would not take the time to discuss it. Possibly the doctor had made a slip of the tongue in speaking of the escape of fluids at the back of the eye, and really meant to say "at the angle of the anterior chamber through Fontanna's spaces and the canal of Schlemm."

DR. HASBROUCK inquired what remedied had been given. He would give the patient something to knock the syphilis out and cause it to re-absorb. Much can be done by the medical treatment of these cases.

DR. HALLETT said that some ten years ago he had given the patient some treatment for the specific trouble, and if he had discontinued it, it was because the man had been advised to go to some one else and have it continued. The eye is hopeless from every standpoint. It is free from pain and presents a fair appearance when the cataract remains in the vitreous chamber, and the patient very sensibly prefers it in the present condition.

PYLOROSPASMUS.

The difficulty of procuring a patient to submit to a gastric demonstration caused me to leave the title on the programme as flexible as possible, but, as our patient is here, we can become more definite and announce Pylorospasmus, With Attendant Ectasia, as the subject.

Spasm of the pylorus as a primary motor neurosis, is never encountered. I have never seen a case, and cannot find a case mentioned in medical literature.

The causes of a spasm of a secondary nature are those factors which produce irritation of the mucous membrane at the outlet of the organ. The two foremost are hyperchlorhydria and ulcer of the stomach. The irritation of indigestible articles of food may also cause spasm. A short time ago, a patient after having eaten a hurried meal of broiled steak, well covered with fat and gristle, which he did not take the trouble to chew, was taken, three hours after, with intense cramps in the stomach, followed by vomiting, which, later, brought up the offending undigested particles of meat. Spasm of the pylorus was, beyond peradventure, the causal factor.

The organic acid produced by fermentation in carcinoma is rarely an etiological factor. Cicatricial tissue, resultant on the healing of an ulcer, is another frequent causal factor.

The modus operandi of the condition is a spasm occurring with food in the organ which causes its delay in advancement; temporary stagnation results and vomiting usually ensues, preceded by crampy pains in the stomach. This repeated at frequent intervals—a condition which occurs if help is not at hand—produces an increase in the size of the organ, with attendant features of isshiochymia.

Time will allow me merely to consider one form, and that is the variety that our case tonight demonstrates—spasm secondary to hyperchlorhydria. The characteristic features of such a case are in the history, a recital of the facts that the patient has suffered from a gastric disturbance which came on late in the afternoon, or woke him from sleep in the morning, both times when the stomach was free from food, and the free acid could produce trouble. Pain next ensued, due to the beginning spasm. Pain is usually burning or crampy, and while the spasm at first is mild and no vomiting

ensues, it becoming more and more intense, vomiting follows and the patient has well-defined attacks of cramp and vomiting.

With the advent of vomiting, the area of the stomach increases, and we now have a well-marked case of what was formerly called "dilated stomach." The patient becomes weak and emaciated, and presents almost the appearance of malignancy.

Now there are two points of differential diagnosis to be considered: First, spasm and carcinoma. The first factor is the longer duration of the case with spasms; it takes two or three years for a case to progress into this state with spasms.

Cancer comes, and the patient goes in eighteen months at the outside. The increased total acidity from 90 deg. to 130 deg. never can occur in cancer. There is never any blood, either in the gastric contents, or in the vomitus, in spasm. The appearance of blood always occurs in cancer sooner or later. Appetite is good in spasm; they do not eat, as they are afraid of the pain which is thereby induced. Cancer always has loss of appetite, and oftentimes repugnance to food.

The second point of diagnosis is separation of benign stenosis, and pylorus spasms will elucidate after the recital of the case.

It is my desire to quote verbatim from my records, and with you build my diagnosis, as was done in treating the case.

CASE HISTORY.

F. W. T.:

Forty-six years, male, clerk, five feet five and a half inches. Present weight, 106 pounds; best weight, 145 pounds, which was five years ago; the loss of weight has been gradual, with periods of temporary gain.

Family History:

Father died at 60, cardiac disease; mother died at 76. pneumonia; evidences of tuberculosis in the family.

Previous History:

Elucidates a varicose vein as the only cause of ill-health up to the time of the advent of his present illness.

General Habits:

Always a hurried eater; never used alcoholics; moderate smoker.

The condition, aside from his failure in health and weight, that brings him to the physician are periodic attacks of crampy pains, followed by gaseous distensions of the stomach, nausea and vomiting. The only cause he can think of is hurried eating.

The disturbance began four or five years ago with attacks of pain at about four or five o'clock in the afternoon.

Two important factors to note here, are, first, the advent of pain some hours after eating, which denotes a hyperchlorhydria, and the fact that pian was present, which shows an organic lesion of the stomach. You cannot get pain in functional disturbances of the stomach.

Now, turning back to the recital of our case, after about one and a half years of these attacks, belching followed by vomitng ensued, with little emphasis on the symptom of nausea. These attacks occurred usually at night, lasted several days, disappeared to return in from two to four months. During an attack, he vomited food-particles of meals taken twelve hours previous. In intervals between the attacks he had pressure and fullness after meals. Brownish fluid was vomited, but he never saw any blood. Oftentimes would vomit about one a. m. Bowels, moved daily; appetite good, but afraid to eat; no repugnance toward food (a point against cancer); thirst increased; deglutition, no pain on swallowing; belches offensive gas, worse after meals. Nausea, at times marked. Sleep, O. K.; memory, O. K.; depressed during attacks.

Physical Examination:

Skin, pale, cachetic; slight jaundice in the sclera.

Teeth, fair. Tongue, heavily furred. Lungs and heart, normal. Liver and spleen, normal.

Stomach. Inspection, no peristaltic waves visible.

Splash down to the umbilicus; organ, inflated with tube and aspirator, shows lower curvature to be 2½ inches below the umbilicus. Lesser curvature not discernible. This is confirmed by inflation of the organ with carbonic acid gas. No marked areas of tenderness. no evidence of any tumor; pylorus not discernible.

Kidneys, normal position. Urine, in 24 hours reduced in quantity; no albumen or sugar present.

Varicose vein on the left leg. Spine, no areas of tenderness.

A test meal, Ewald, removed in one hour; residue eight ounces, turbid, dark, very sour, evidences of food of previous meals poorly digested; lactic acid present in a trace; starches well-digested; total acidity 90 deg., free hydrochloric acid 45 deg.

We can now eliminate cancer from the case, on the following symptoms:

1. Lactic acid not present in pathological amounts.
2. No blood present at any time.
3. Long duration of the case.
4. Hydrochloric acid findings, high.
5. Frequent periods of improvement in symptoms.
6. Presence of the Rhomdankalium reaction.
7. Absence of enlarged glands in cervical or inguina.

Entering the diagnosis between an atony of the organ and occluded pylorous, I am beginning to doubt the existence of an enlarged organ without an inclusion of the pylorus. I have been unable to get my hands on a case of increased area due to muscular weakness, and I am about to discard this disease as being a clinical identity. Arriving at this stage, we then have an

obstruction of the outlet of a non-malignant nature. It must be either an organic stenosis or a spasm. The high degree of acidity puts us on our guard for the latter.

September 26th.

A meal of boiled rice, spinach and tomato given on the previous evening, and a Boas lactic acid free meal in the morning. Result, remnants of food from the night previous, but no lactic acid; meal sour. The treatment up to this time had been a proper diet, anti-ferments and alkalis.

September 30th.

Gained four pounds free of all symptoms.

October 4th.

Stomach aspirated fasting in the morning; sour mass from the night previous; hydrochloric acid present; no lactic acid; no Oppler Boas bacilli; another point against cancer.

October 7th.

Double test meal; remnants of the first meal present on lavage.

October 14th.

Weighing 113 pounds, free from all symptoms. test meal shows total acidity of 96 deg., free hydrochloric acid 70 deg.

October 25th.

Test meal much better digested on removal.

October 30th.

Weight, 116 pounds.

Up to the time lavage had been practiced twice a week. Lavage now instituted once a week.

November 16th.

No symptoms; weight, 120 pounds. Ewald meal, total acidity 82 deg., free HCL 68 deg.

December 20th.

Stomach entirely empty 1½ hours after test meal, showing splendid motility, impossible in a stenosis.

January 17th.

Weight, 120 pounds. Remnant test shows 120 per cent.

February 14th.

Weight, 130 pounds. Patient now seen only at intervals of two weeks. and on examination with a tube presents little trace of food taken on the previous evening.

March 14th.

Weight, 131 pounds.

April 11th.

Weight, 133 pounds. No symptoms, total acidity 76 deg., free HCL 60 deg.

Our patient, then, without a setback, has gained 27 pounds, and during this time has been practically without a subjective symptom. During the

course of the treatment, the diagnosis of spasm of the pylorus. due to excessive acidity, has been arrived at, and stenosis of the pylorus from internal diminution and pressure from without had been eliminated on the following reasons:

1. High state of the findings of the HCL.
2. Relief of the symptoms on treatment instituted to decrease the irritation from the excessive acidty.
4. Absence of any visible peristaltic waves.
5. Improvement occurring with lavage at infrequent intervals.
6. Evidence in the history of a hyperchlorhydria preceding severe symptoms for some time.
7. Against stenosis is the absence of all symptoms pointing to an ulcer, or any symptoms of increase in size or displacement of the surrounding organs.

Roy Upham, M. D.,
300 McDonough Street,
Brooklyn-New York.

DR. SLOAT said that the demonstration was a most interesting and instructive one. Dr. Upham had referred to one point that should be emphasized—the difficulty in certain cases of ulcer of the stomach of making the diagnosis. Every one has seen cases that have gone on for eight or ten years without clear evidences, such as hyperchlorhydria, periodic vomiting, etc. Dr. Einhorn has devised a test which gets over some of the difficulties. In the evening the patient while in a fasting condition swallowed the ordinary stomach bucket enclosed in a gelatine capsule. This bucket is attached to a silk thread, and is allowed to pass down some 75 c.m. and the thread is then attached to some part of the clothing. The bucket remains in place all night and is withdrawn the next morning. If this is tried it will often be found that there is some obstruction when the bucket passes into the stomach, and also when it is withdrawn through the mouth. The thread. however, is seldom broken. To be sure the bucket has been in the duodenum during the night, the contents of the bucket are examined and found to contain the fat-spitting contents of the intestine. In cases of ulcer there will be brown discolorations where the thread has come in contact with the ulcerated surface, and by measuring the thread a pretty fair estimate can be made as to the location of the ulcer; and if dietetic measures are not successful the case can be turned over to the surgeon and he can operate with a pretty fair idea of the location of the ulcer.

DR. ROY UPHAM said that Dr. Einhorn had appropriated another man's idea, and that he himself had little faith in these complicated tests that are so frequently devised at the present time. They are not necessary to make a diagnosis. Gastric diagnoses are not easy to make, but for hmself he would prefer to go to bed for seven to ten days under a suitable ulcer treatment rather than to have a stomach bucket let down and drawn up in the manner devised, especially if it was thought that there was an ulcer in the stomach.

Dr. Hemmeter, of Baltimore, had devoted a number of pages of his book to a similar task, and on inquiry by the speaker into further details he replied that it was impractical and had been discarded. All that is necessary can be learned by studying the symptoms of the patient, plus the results of a number of simple tests fo recovered ingesta.

PYORRHŒA ALVEOLARIS: THE UNNECESSARY DISEASE.

By Dr. Brush.

Discussion.

DR. SLEGHT said that he had prevailed on a patient whose dentist said that he had pyorrhoea to have two teeth drawn, and he would like Brush to look at them and see whether he thinks it was case of pyorrhoea.

DR. MOORE told of a woman who had had Rigg's disease without satisfactory treatment until a year and a half before pregnancy started, when she had careful treatment once or twice a week and the condition showed marked improvement. Then she became pregnant and had a distaste for food, but no nausea or vomiting. She continued to consult the dentist and used a mouth-wash, but notwithstanding the best endeavors the discharge from the mouth was very pronounced and constant during the pregnancy. After the termination of her pregnancy she continued the treatment and the improvement was very pronounced, and she has since had no trouble from the pyorrhoea.

DR. BRUSH, replying to Dr. Sleght, who had stated that a creosol treatment was being used by a Newark dentist. I cannot speak definitely regarding this particular treatment without knowing more of the particulars, as there are several of these preparations that have become quite popular with our Newark friends. Some time ago I received a visit from a layman who had prepared such a remedy, calling it "dentinol and pyrrhocide;" upon examination it was found to be a vile concoction with a disagreeable odor and entirely unfit to be inflicted upon a refined patient. It appeared to contain a low grade phenol among its other ingredients. The man declined to state either the formula or its ingredients. There are several of these preparations being exploited and all are looked upon as nostrums by ethical dentists. We, as dentists, have not, as yet, found any remedy that gives satisfactory results unless it is accompanied by thorough instrumentation; with this, however, almost any treatment that will tone up the tissues will produce a fair result.

Upon the teeth presented for inspection there is present sufficient calcareous matter to cause inflammation and probably a flow of pus. From their appearance it would seem quite possible to have restored them to health by instrumentation alone, planing the roots smooth so that fresh adhesions could take place. However, it is difficult to pronounce a definite opinion without knowing the conditions of the mouth from which they came; the condition of the other teeth, the occlusion, the pressure of antagonizing teeth, etc.

DR. JOSEPH HELD, of Philadelphia, has recently given to the profession a compound which he calls "biflouride of ammonium;" this, he claims, is a solvent for salivary calculus and when carefully applied to the deep pus pockets will dissolve the irritant to such an extent that upon a subsequent visit of the patient it can be literally washed out of the pocket and that it materially assists instrumentation. In all of these various treatments, however, instrumentation takes place and those that are having considerable clinical experience in this line feel that this is the key to the situation and the secret of the cure. Unless the irritant is removed the results are not satisfactory. In some cases the point of irritation is so small and the shape of the root is such that the operator is unable to locate or reach it and in such a case does not get the best results with that particular tooth.

In reply to an inquiry regarding Rigg's disease occurring in pregnancy and whether or not this indicated anything as to the systemic nature of the disease, Dr. Brush said he had not had any experience with this combined condition, but would say that in such case it was probably due to the condition of the mouth previous to the pregnancy and the fact that the mouth could not be kept in a good hygienic condition during this period. There is often nausea and a distaste for anything in the mouth which preclude any local treatment. If the mouth was in bad condition previous to the pregnancy and was not well cared for one might expect some increase of the disease, but he did not think that pregnancy alone would produce the condition.

DR. BRUSH stated further that in his own experience and that of other men, efforts were often made to save teeth that were so diseased that they were in a hopeless condition and had really become like foreign bodies which nature was endeavoring to remove, and the efforts to save them were ill advised. In such cases it is better to extract the teeth at once and restore the mouth to a healthy condition rather than make useless attempts to save them.

DR. DANIEL E. S. COLEMAN, President. DR. GUY B. STEARNS, Secretary

TRANSACTIONS OF THE MATERIA MEDICA SOCIETY OF NEW YORK.

Wednesday Evening, April 28, 1909.

Meeting called to order by Vice President Sloat.

Doctor House was appointed Secretary pro tem.

Dr. Dearborn, the speaker of the eevning, announced as his topic The Therapeutics of Skin Diseases, and said:

My topic covers a large field and one which, I think, can be more methodically and intelligently viewed if considered under somewhat arbitrary headings. With that thought in mind, therefore, I shall treat the theme very much as I would if speaking to my class at the college, dividing its subject matter into five parts and considering them under five arbitrary headings. Of course, the therapeutics of skin diseases cannot practically be differentiated in this manner, for they so overlap and run into each other that a line of demarkation is not possible.

We will consider five divisions of the topic in about this order:

1. Causal Treatment, which involves removal of the cause.

2. Physiological Treatment, which means any measure which makes possible a return to normal conditions.

3. Pathogenetic Treatment, which is medicinal and has largely to do with the symptomatology.

4. Mechanical Treatment, which embraces the enormous field of local application, as the use of lotions, powders. salves, etc.

5. Operative Treatment, which has largely to do with methods which approach, at least, surgical procedures, although they may be very important from that point of view.

As I have already suggested, these divisions of the subject are bound, practically, to overlap. I can best illustrate that by saying that if you have a case of skin pigmentation due to the absorption of the toxins of some germ of intestinal activity and you give your patient a very pronounced laxative and at the same time put him on a diet inclined to be laxative in its effects you do two things. You remove the cause by the use of your pronounced laxative and at the same time you employ physiological treatment by the use of diet. That is an instance of what I mean by two treatments running into each other.

I shall show you a little later a number of photographs of typical cases which I have treated.

Our first division, then, is

CAUSAL TREATMENT.

Of course, we all understand that causal treatment in the case of para-

sitic affections means the removal of the parasite. This is not necessarily limited to external parasites, but applies to the internal as well; for you will remember that we class as parasitic an enormous group of diseases, due to animal and vegetable parasites, such as erysipelas, tuberculosis, syphilis and many others.

Causal treatment may not be entirely medical. You may, as you know, destroy the parasite by anti-parasitic lotions, or by electricity, or by the use of the Iodide of Potash, the latter treatment being quite famous in the old school and, in cases of actinomycosis, and blastomycosis, perhaps, the best. I remember a particular instance of this exhibited at an American Institute meeting some four or five years ago; a case of blastomycosis, where they wanted a diagnosis and no one there had ever seen a case before. It was suggested that the treatment be along the lines of the indicated remedy. The doctor who had been treating it said he had been doing that for some time without results. I suggested that he use Iodide of Potash in saturated solution and locally Bichloride of Mercury, one eto five hundred. He afterwards wrote me that the case recovered in three months' time. That is an example of what is meant by causal treatment. The Iodide of Potash was strictly anti-parastic.

Of course, causal treatment involves the use of a great many very simple anti-parasitics, as Sulphur in ointment or in baths; Mercury, internally, by vapor, inunctions and hypodermically. It has a big field in the treatment of syphilis particularly.

You have also the use of many of the so-called toxins and the various serums, as Sclavo's serum for anthrax, of which we have used very little in this country, our treatment being largely surgical. But while all anti-parasitic treatment is causal, all causal treatment is not anti-parasitic.

The second variety of treatment involved in the therapeutics of skin diseases stands pre-eminent in both schools of medicine as of great import; and that is the physiological treatment. Anything that will restore normal conditions of health in the line of diet, clothing, climate, habits, occupation, etc., comes in this group; and it means the rectifying of all varieties of irregularities in eating, thinking, smoking and habits of life of the individual—in short that large group of recommendations as to diet, work, and exercise which every physician believes in.

In skin diseases of the dietetic group, regulation of the diet is sometimes the most important part of the treatment and usually is directed toward the reduction of one particular article of food, the starches. That is a thing which the American public overdoes. It has been stated by authorities that, per capita, we consume the greatest amount of starch of any nation in the world. If we took a proportionate amount of exercise that would be all right; but the class of patients that come to us do not do that. Most of the cases embraced in the idiopathic and dietetic groups are instances of overeating. They are using their brains and no other part of their anatomy.

The question of water drinking comes in here. I believe that a great thing in water drinking is not to overdo it. It is possible to drink too much

water. You tell some people to drink all the water they can and they will tell you they have drunk as much as two gallons in a day. This is too much for the average patient.

The question of clothing is equally important. A person may be too heavily or too lightly clad and may be wearing wool where something less irritating to the skin would assist in a cure.

The third heading to be considered is the one of greatest importance to our school of medicine and one which, in the field of dermatology, is apt to make a man a very enthusiastic prescriber if he will remember its limitations. I have reference to the pathogenetic treatment. It is possible to get drug effects from the application of an ointment to the skin or from painting the mucous membrane and sometimes it is very desirable to do it that way. I do not think the question of potency has any particular bearing on anything I can say about the pathogenetic treatment of skin diseases as that is naturally governed by the physician's own instincts and the personality of the patient. My own range of potencies is quite extensive. Some drugs, of course, we seldom ever use low. They are principally the tissue remedies and metallic compounds. The vegetable compounds we are very apt to use lower.

I consider that where a group of symptoms in a disease like syphilis calls for Iodide of Potash and it is given to accomplish something very rapidly, as in ulcers or tertiary symptoms, to relieve pressure from gummas, for instance, and is given absolutely without regard to symptoms, the treatment has been purely anti-parasitic and nothing else and in no sense pathogenetic.

The question of the pathogenesis of any particular drug is the same in dermatology as in other branches of medicine. As in other forms of disease you want the totality of symptoms on which to prescribe. I have had it brought to my mind many times that I did not go over all the symptoms of a particular case as I should have done. I have given too much prominence to the symptoms which I could see, whereas in the treatment of skin disease you should not pay any more attention to the objective symptoms than to the subjective group. You want to remember that many skin diseases are but external manifestatons of internal trouble. Hence, I think it is quite essential that you treat the internal trouble, otherwise you are wasting time. Take, for instance, erysipelas, we ordinarily consider that due to a form of vegetable parasite, and yet there is not one of us who has had any success at all with that disease who would thnk of treating it in any other way than homœopathically. I never treat uncomplicated erysipelas with any local treatment except for soothing purposes. In the Metropolitan Hospital it is the uniform rule that cases of erysipelas that are not complicated have no local treatment except a little glycerine to soothe the pain and that the treatment be strictly homœopathic; and we have been able to prove that in many of the low forms of parasitic diseases the homœopathic treatment is the successful treatment, its action being to restore some, much of the normal tone to the affected tissues that a rejuvenatoin is possible.

The mechanical treatment, for the old school, is practically their main re-

liance. The average dermatologist in this town, particularly the oldest ones, devotes almost all his energy to the treatment of these skin diseases locally. They do that by means of lotions, ointments, powders and caustics of all varieties and also by means of support and pressure by the use of bandages and adhesive plasters or they cover over the surface as with Collodion. And all this variety of outward treatment plays a most important part with the more gnorant class of people who, at least, many of them, feel that they must have some dirty substance smeared over them or nothing is being done.

We accomplish the same results in our clinical work at Flower and the Metropolitan, as in a great many other hospitals, with less expense, by using the simple non-mercurial, non-irritating oils and fats for diseases of that character. In place of using medicated salves, we use sweet oil or lanolin, and vaseline in place of carbolated ointments, etc. I do not know how many cases of eczema I have seen through at Flower with sweet oil and the indicated remedy. Sweet oil is non-irritating and does not interfere with anything you are doing internally or in any other way.

This subject of mechanical treatment is a very large subject and must be adapted to the individual case. Whether you see an anti-pruritic, or something soothing for a burn, or a counter-irritant, is something you decide to suit yourself for each case. In this connection I want to speak about the use of a remedy which is not so largely used as it might be in dermatology. I refer to Adrenalin Chloride locally for the relief of hyperemia. It relieves it on the skin as well as elsewhere. For a case of acute eczema I do not know anything that will allay the inflammation so quickly, and it will keep down the inflammation and the itching as well. I will not go into the list of irritants, anti-pruritics, lotions, etc., it would simply be an endless recital of a lot of things that you already know of or can find out about. But I will ask you not to forget that this mechanical group also embraces physical therapy. I say that because physical therapy can be used for many different purposes, some of which come under the head of operative not mechanical methods of treatment. Electricity can also be used as a destructive agent of malignant growths; also as an anti-pruritic, which is purely mechanical. The field of physical therapy might conveniently be divided among the causal mechanical and operative forms of treatment.

In the fifth group, the operative, we classify all incisions, excisions, scarifications, skin-grafting and destructive procedure generally; something which is more than mechancal and involves the use of instruments of some kind.

As I have said before, these terms run into each other. There are no hard and fast lines drawn between them. You are well aware of the fact that when you are using the X-ray on eczema, you are, in a sense, using it as a pathogenetic agent, and also, it is partially mechanical and operative; so that you have three of these methods of treatment in that one agency or, again, take the treatment of scabies, which you know is a rather lively parasite. The ordinary treatment is limited to the use of external means and is anti-parasitic. You give sulphur baths and use sulphur ointments and that

sort of thing, and yet I firmly believe that if the patient's nervous system is run down, it needs to be toned up, and you have got to use some sort of treatment with that in view. In the other school of medicine they use their tonics, Nux vomica, Quinine and Iron. I usually give a remedy which covers as many of the symptoms as possible, such as sleeplessness, indigestion, headaches, etc., and the list of available remedies might comprise a pretty large group. We try to make use in all these cases of as many forms of treatment as will do the patient good from Sulphur inside and outside to Sulphur outside and Bryonia inside.

There is one parasitic disease which requires strenuous methods. I refer to the so-called Dhobie Itch, South American Itch or Manila Itch; very general terms for a very intractable affair which is brought to us by people who have been in the tropics. Its peculiarity is that one member of a family may have it for a long time and not give it to anybody else; showing its fungus nature. It has nothing to do with the ordinary itch. There is one section of Long Island where there have ben hundreds of cases in the last two years, the Jamaica section. The worst case I ever saw was in the Jamaca Hospital. It absolutely destroys a person's nervous system and makes a wreck of him. He loses appetite, loses weight, cannot sleep, and has all the symptoms that go with these conditions. That germ needs internal treatment and it is just as important that it should have parasitic treatment also of the most strenuous nature. I give baths of solution of hyposulphite of soda and put on externally an ointment composed of salicylic, tannic and carbolic acids. It is the only thing to do. I believe a physician who uses internal treatment alone for a parasitic disease which is contagious is making a great mistake. I feel very strongly about that. Parasitic diseases should be and must be stamped out. We have got to take into consideration the community as well as the individual in the treatment of such diseases.

The question of therapeutic treatment of skin diseases has come to depend a good deal upon the individual diseased. We have got to take into consideration the age of the patient for it has a great deal to do with the strength of the local treatment, as well as with the nature of the internal treatment. Every case of skin disease cannot stand the same strength of sulphur ointment. Every case of eczema cannot stand the X-ray, and every case of psoriasis cannot stand crysartbim or pyrogallol.

The photographs referred to, about sixty in number, were exhibited and commented upon by Doctor Dearborn.

BOOK REVIEWS.

A Brief Summary of the Practical Value of Water for Disease, Students and Practicians of Medicine. William H. Dieffenbach, M. D., United States Delegate and Vice-President of the First International Congress on Radiology and Ionization, Liege, Belgium. Former Professor Bacteriology, New York Medical College and Hospital for Women. Professor of Hydrotherapy, New York Homœopathic Medical College and Flower Hospital. Physical Therapeutist to Volunteer St. Gregory's Hospital. Electro-Therapeutist to Flower and Hahnemann Hospitals, etc., etc. With 39 illustrations in the text. New York. Rebman Co. Cloth, $3.00.

Dr. Dieffenbach deals with his subject in a masterly manner and gives to the reader a clear-cut and practical treatis of this branch of physical therapeutics. In the first few chapters he deals with the physiological effects of water in its various forms of administration; continuing with more detailed description of the different baths and clearly defining the indications or contra-indications of each. The book also describes and gives the indications of packs, compresses, bandages and foments.

Of particular interest is chapter 24, dealing with diseases of the respiratory tract. Here the author shows how much can be done with hydrotherapeutic measures in that most fatal disease, pneumonia. The book is well worth the price if only for this one chapter.

The paper and type are both of good quality and the illustrations are excellent.

American Institute of Homœopathy, Transactions of the Sixty-Fourth Session.

This volume contains only the business done at the Institute meeting held in Kansas City, Mo., June 22, 1908, and the official list of members.

GASTRO-INTESTINAL IRRITATIONS AND THEIR TREATMENT.

By Brose S. Horne, M. D.

Ex-Physician Indiana State Prison, Marion, Indiana.

Enteritis is only a clinical expression and the disease is due to many causes. The most fruitful cause is drinking water contaminated by the discharges from diseased patients. Exposure to cold, bad food, through nervous influence and by direct irritation of the mucous membrane, may produce individual cases of the catarrhal forms. In army life this disease is quite frequent and is described under the name of dysentery. In crowded places, as in the army or in prison, epidemics will arise and frequently the whole mass of humanity will be taken down with this dreadful disease.

There are many micro-organisms found in the discharges from these patients. One is the amoeba dysenteriæ, claimed by some to be the main cause, but it is doubtful if any one organism can be pointed out as the specific cause of the trouble. It is a settled question not that some poison introduced into the system produces these gastro-intestinal troubles such as gastro-enteritis, entero-colitis, epidemic dysentery, etc.

We need not dwell on either particular nosological classification as the treatment is about the same in either one of the entities. The common sympoms met with in these disorders are about the same. They will commence with a light form of gastro-intestinal catarrh. After the stage of incubation which may last from a few hours to a few days, symptoms of dyspepsia and diarrhœa set in. There is anorexia, heartburn, nausea, vomiting, borborygmus, often pain in the abdomen and copious fluid discharges. In some cases there is violent griping and collicky pains with a sensation of depression. The patient in some cases is unable to leave the stool. The tenesmus is frightful, making the patient not only a misery to himself, but to his friends as well. Often the patient will sit at stool hours at a time until he becomes so faint and weak that he cannot leave it without assistance. There is great depression in these cases. The constant nausea, with occasional vomiting, and tenesmus causes great prostration.

During the winter of 1901-1902 an epidemic started in Michigan

City, Indiana. At that time the writer was physician of the Indiana State Prison. Hundreds of cases developed; the inmates of the prison were infected as well as some of the officers of the institution. The general suffering was great, indeed. In these cases all of the symptoms were those of a case of poisoning. The skin is hot and dry, the tongue is heavily coated, the face soon wears an anxious expression, the abdomen becomes distended; there are constant discharges of mucus, blood and pus, some cases would go to stool as high as two hundred times in twenty-four hours. In the worst cases the patient would sit or lie upon the bed most of the day not caring, apparently, whether he lived or not. The first discharges, as a rule, in these cases were like the white of an egg; later on they would be tinged with blood. The general symptoms were alarming. At times a person would be tempted to call the case cholera. In some cases there would be fever and in others there would be none. To give some idea of the cases, I will cite one or two:

John S., age 32, white, was taken sick with a discharge of mucus from the bowels. He had tenesmus, griping pains, went to stool one hundred and twenty times the first twenty-four hours. He was given the ordinary treatment without any relief whatever. After the first forty-eight hours his bowels were washed out with a solution of hot water and Glyco-Thymoline, two ounces to each pint of water. He was given a few doses of Dover's powder and a half a tablespoonful of Glyco-Thymoline in a little water every two hours. In forty-eight hours from the beginning of this treatment he was up and around. The constant vomiting he had disappeared after the third dose of Glyco-Thymoline.